Unannounced Care Inspection

Name of Establishment:	**Slemish House**
RQIA Number:	**1378**
Date of Inspection:	**11 January 2015**
Inspector's Name:	**John McAuley**
Inspection ID:	**IN018656**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of Establishment:	Slemish House
Address:	28 Broughshane Road Ballymena BT43 7DX
Telephone Number:	02825649772
Email Address:	dorothy.mckeefry@carecircle.co.uk
Registered Organisation/ Registered Provider:	Slemish House Ltd Mr Ciaran Sheehan
Registered Manager:	Mrs Dorothy McKeefry
Person in Charge of the Home at the Time of Inspection:	Staff Nurse Sreejith Mohandas Then joined later by the registered manager
Categories of Care:	NH – I, PH, PH (E)
Number of Registered Places:	45
Number of Patients Accommodated on Day of Inspection:	39 plus 2 patients in hospital
Scale of Charges (per week):	£567 - £609
Date and Type of Previous Inspection:	5 March 2014 Primary Unannounced
Date and Time of Inspection:	11 January 2015 10:30am – 2:45pm
Name of Inspector:	John McAuley

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year are required.

This is a report of an inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection are being met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

The Regulation and Quality Improvement Authority aims to use inspection to support providers in improving the quality of services, rather than only seeking compliance with regulations and standards. For this reason, annual inspection involves in-depth examination of a limited number of aspects of service provision, rather than a less detailed inspection of all aspects of the service.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the Provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)
- Other published standards which guide best practice may also be referenced during the Inspection process

4.0 Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with the Registered Nurse Manager
- Discussion with staff
- Discussion with patients and three visiting relatives
- Review of a sample of care plans
- Review of the complaints, accidents and incidents records
- Observation during a tour of the premises
- Evaluation and feedback

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	**20**
Staff	**6**
Relatives	**3**
Visiting Professionals	**0**

6.0 Inspection Focus

Prior to the inspection, the responsible person/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible person/registered manager in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

However, due to workload pressures and contingency measures within the Regulation Directorate, the themes/standards within the self-assessment were not inspected on this occasion.

This inspection sought to establish the level of compliance being achieved with respect to the following DHSSPS Nursing Homes Minimum Standard and to assess progress with the issues raised during and since the previous inspection:

Standard 19 - Continence Management;

Patients receive individual continence management and support.

The inspector has rated the home's Compliance Level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Slemish Private Nursing home is situated on the Broughshane Road in Ballymena County Antrim.

The nursing home is owned and operated by Care Circle Limited.

The registered manager is Mrs Dorothy McKeefry who been so for over five years.

Accommodation for patients is provided in single and double bedrooms over two floors. Access to the first floor is via a passenger lift and stairs.

Communal lounges are provided for in both floors of the home and a dining area is provided in the ground floor level.

The home also provides for catering and laundry services on the ground floor.

A number of communal sanitary facilities are available throughout the home.

The home is registered to provide care for a maximum of forty five persons under the following categories of care:

<u>Nursing care</u>

I	old age not falling into any other category
PH	physical disability other than sensory impairment under 65
PH(E)	physical disability other than sensory impairment over 65 years

8.0 Executive Summary

The unannounced inspection of Slemish Private Nursing Home was undertaken by John McAuley on Sunday 11 January 2015 between 10:30am and 2:45pm. The inspection was facilitated by Staff Nurse Sreejith Mohandas who was in charge, until the Registered Manager reported later in. The registered manager was available for verbal feedback at the conclusion of the inspection.

During the course of the inspection, the inspector met with patients, staff and three visiting relatives. The inspector observed care practices, examined a selection of records, and carried out a general inspection of the nursing home environment as part of the inspection process.

As a result of the previous inspection conducted on 5 March 2014 one requirement and one recommendation were issued. A review of these, found all were addressed within timescale. Details can be viewed in the section immediately following this summary.

The DHSSPS Nursing Homes Minimum Standard 19 on Continence Management was reviewed on this occasion. The review found that there were individualised assessments and care plans pertaining to continence care and staff are in receipt of training in this area. General observations of care practices found that patients' personal care needs were attended to promptly and with privacy and sensitivity. This standard has been overall assessed as compliant.

Discussions with patients and visiting relatives were all positive, in respect of the provision of care and their relationship with staff. Details of this consultation are in 11.0 of this report.

Observations of care practices found that duties and tasks were carried out at an organised, unhurried pace, and patients were treated with dignity and respect.

Discussions with staff on duty, confirmed staff were positive about their roles and duties, the teamwork and managerial support. No concerns were expressed.

The home was clean and tidy with a reasonable décor and furnishings being maintained, although some areas were dated but fit for purpose.

Conclusion

The inspector can confirm that at the time of this unannounced inspection the delivery of care to patients was evidenced to be of a good standard. There were processes in place to ensure the effective management of the issues inspected. Patients were observed to be treated with dignity and respect.

One requirement was made as a result of this inspection, in relation to the illegibility of a significant number of written entries in patients' care records. This requirement is detailed in 11.0 of this report and in the attached quality improvement plan (QIP).

The inspector would like to thank the patients, staff and registered manager for their assistance and co-operation received throughout this inspection.

9.0 Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	13 (7)	It is required that the registered person reviews all bedroom sink vanity unit doors to ensure that surfaces are intact to facilitate effective cleaning.	The vanity unit doors have been actioned to ensure effective cleaning.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1.	20.2	It is recommended that all emergency equipment is checked on a regular basis with a record maintained that is dated and signed by registered nursing staff.	The weekly checks on emergency equipment is signed and dated by nursing staff.	Compliant

9.1 Follow up on any issues/concerns raised with RQIA since the previous inspection such as complaints or safeguarding investigations.

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Since the previous inspection in March 2014, RQIA have not been notified by the home of ongoing investigations in relation to potential or alleged safeguarding of vulnerable adults (SOVA) issues.

10.0 Inspection Findings

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.1 Where patients require continence management and support, bladder and bowel continence assessments are carried out. Care plans are developed and agreed with patients and representatives, and, where relevant, the continence professional. The care plans meet the individual's assessed needs and comfort.	**COMPLIANCE LEVEL**
Inspection Findings:	
A review of patients' care records found that there were individualised assessments in place of continence care needs and management of same. The outcome of these assessments, including the type of continence products to be used, was incorporated into patients' care plans. The care plans had supporting evidence of patient / or their representative consultation. Added to this, general observations of care practices found that patients' personal care needs were attended to promptly and with privacy and sensitivity. There was also found to be adequate provision of aids and equipment in place to management this area of care.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT **Patients receive individual continence management and support**	
Criterion Assessed: 19.2 There are up-to-date guidelines on promotion of bladder and bowel continence, and management of bladder and bowel incontinence. These guidelines also cover the use of urinary catheters and stoma drainage pouches, are readily available to staff and are used on a daily basis.	**COMPLIANCE LEVEL**
Inspection Findings:	
All staff have received training in continence management and there are guidance, with policies and procedures on continence management, including catheter care and stoma care. Added to this there was a wide range of guidance and information in place to direct and support staff on continence management.	Compliant

STANDARD 19 - CONTINENCE MANAGEMENT Patients receive individual continence management and support	
Criterion Assessed: 19.3 There is information on promotion of continence available in an accessible format for patients and their representatives.	**COMPLIANCE LEVEL**
Inspection Findings:	
Information is available on the promotion of continence and on request can be made available on accessible format for patients and their representatives. This includes evidence that as appropriate patients are referred to continence management services to help assist in the care planning of such assessed needs.	Compliant
Criterion Assessed: 19.4 Nurses have up-to-date knowledge and expertise in urinary catheterisation and the management of stoma appliances.	**COMPLIANCE LEVEL**
Inspection Findings:	
Discussions with one of the nurses on duty confirmed that they are in receipt of up to date training in urinary catheterisation and stoma care management.	Compliant

Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

11.0 Additional Areas Examined

11.1 Patients / Residents' views

The inspector met with a large number of patients throughout this inspection. In accordance with their capabilities, all confirmed / indicated that they were happy with their life in the home, the provision of care, their relationship with staff and the provision of meals.

Some of the comments made included statements such as;

"Everyone is very kind to me"
"Everything is perfect, I am very happy"
"I am at ease with the staff, they all treat me well"
"The meals are all lovely"
"There are no problems here, it is a great home"

No concerns were expressed or indicated**.**

11.2 Staff views

The inspector met with six members of staff of various grades on duty at the time of this inspection. All spoke positively about their roles and duties, the teamwork and managerial support. Staff informed the inspector that they felt a good standard of care was provided for and no concerns were expressed.

11.3 Relatives' views

The inspector met with three visiting relatives at the time of this inspection. These relatives spoke in complimentary terms about the provision of care and the kindness and support received from staff.

No concerns were expressed.

11.4 General environment

The home was found to be clean and tidy with a reasonable standard of décor and furnishings being maintained, although some areas of décor were dated but fit for purpose.

11.5 Care practises

Discreet observations of care practices throughout this inspection, evidenced patients being treated with dignity and respect. Staff interactions with patients were observed to be polite, friendly, warm and supportive.

Care duties and tasks were organised and carried out in an unhurried pace. Frailer patients were found to be care for in an attentive, caring manner and appeared in no obvious discomfort.

The supervision and assistance with the Sunday dinner time meal found this to be carried out in an appropriate manner with an appetising meal provided for in conducive surroundings.

11. 6 Fire Safety

A review of the home's fire safety risk assessment, dated 14 March 2013, was undertaken. Evidence was in place that the recommendations from this assessment had been attended to. It was reported by the registered manager, that a fire safety risk assessment was carried the previous week and the report of same had yet to be issued.

Fire safety training, including fire safety drills was found to be maintained on an up to date basis with staff. There were a programme of fire safety checks maintained in the home, and these were recorded on an up to date basis. At the time of this inspection, all fire safety exits were clear and no fire safety doors were wedged open.

11.7 Care Records

A review of care records, included accident / incident reports found there were a significant number of written entries that were illegible. A requirement has been made for this practice to be reviewed with staff accordingly.

11.8 Complaints

It is not in the remit of RQIA to investigate complaints made by or on the behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

A review of the record of complaints together with discussions with the registered manager confirmed that expressions of complaint are taken seriously and managed appropriately.

11.9 Accident / incident reports

A review of the home's accident / incident reports from 1 September 2014 was undertaken. As detailed in 11.7 there were a significant number of written entries that were illegible. However those that were legible were found to be managed appropriately and signed off by the registered manager as reviewed / inspected.

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Dorothy McKeefry, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

John McAuley
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Appendix 1

<table>
<tr><th colspan="2">Section A</th></tr>
<tr><td colspan="2">Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.</td></tr>
<tr><td>Criterion 5.1
• At the time of each patient’s admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient’s immediate care needs. Information received from the care management team informs this assessment.
Criterion 5.2
• A comprehensive, holistic assessment of the patient’s care needs using validated assessment tools is completed within 11 days of admission.
Criterion 8.1
• Nutritional screening is carried out with patients on admission, using a validated tool such as the ‘Malnutrition Universal Screening Tool (MUST)’ or equivalent.
Criterion 11.1
• A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.

Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.1 – Following Care Circle Policy on Admission, a Nurse carries out and records Assessment of Daily Living and initial Risk Assessments using a validated assessment tool. Information received from Care Management Team informs this assessment.

5.2 – Assessment of Daily Living is completed on admission and updated and reviewed during 1st week. Roper Logan Tierney model used. Care Plans are completed based on these assessments together with information from Care Manager and Resident/Representative.</td><td>Compliant</td></tr>
</table>

8.1 – Nutritional screening is carried out on admission using a validated tool, MUST Assessment. Nutritional needs are assessed, discussed and documented during pre-admission assessment. 11.1 – A Pressure Ulcer Risk Assessments that includes nutritional, pain and continence assessment combined with Clinical judgement is carried out on all Residents prior to admission to the home when possible and on admission to the Home.	

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<tr><td>Criterion 5.3
• A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.
Criterion 11.2
• There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.
Criterion 11.3
• Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.
Criterion 11.8
• There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.
Criterion 8.3
• There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.

Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.3 – A named nurse system is in place for each Resident within the Home. Residents and relatives are aware of their named nurse. It is the responsibility of that Nurse to plan and agree care with the Resident and their representative. Care Plans are updated monthly by the named nurse or by the nurse on duty should there be a change in Resident</td><td>Compliant</td></tr>
</table>

needs. Visiting Health professionals use our multi-disciplinary notes to records visits or instructions for care. 11.2 – Referral arrangements are in place to obtain advice and support from relevant Health professionals including those with expertise in Tissue Viability. 11.3 – Where a Resident is assessed at risk of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant professionals. 11.8 – There are referral arrangements to relevant Health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration. 8.3 – If a Resident is noted to have decreased appetite or weigh loss – their nutritional status is reassessed and MUST (Malnutrition Universal Screening Tool) guidelines followed. Referral is posted to Community Dietitian but telephone contact can be made is staff feel nutritional treatment plan needs urgent review. A nutritional treatment plan is developed by Dietitian and implemented by staff.	

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<tr><td>Criterion 5.4
• Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.4 – Daily evaluation of identified care needs are recorded twice daily by nurses. If care needs have altered, assessment of needs and care plans are amended by the nurse completing the daily evaluation assessments of activities of Daily Living and Care Plans are reviewed and updated monthly by the named nurse. A selection of care plans are audited monthly by the Manager / Deputy Manager.</td><td>Compliant</td></tr>
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<tr><td>Criterion 5.5
• All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.
Criterion 11.4
• A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.
Criterion 8.4
• There are up to date nutritional guidelines that are in use by staff on a daily basis.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.5 - Examples of evidence based practice and guidelines followed for nursing intervention and pressure ulcer risk assessment (Braden) Malnutrition Universal Screening Tool, and Action Plan, Crest Guidelines on management of Enteral feeding systems falls Risk Assessments and Action Plan. Staff are supported with training in any area they feel they would like to further develop skills and or competency, if management feel it would be beneficial.
11.4 – The validated pressure ulcer grading tool is Braden. Active is sought from Tissue Viability Nurse for relevant treatment plan. All nurses have received training on wound/pressure ulcer management. The majority of care assistants have also received training in wound/pressure ulcer prevention and management.
8.4 – Up-to-date nutritional guidelines are available for all grades of staff. A staff nurse has responsibility for ensuring nutritional needs of patients are being met and that staff are kept up-to-date with changing nutritional needs and nutritional treatment plans.</td><td>Compliant</td></tr>
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Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
5.6 – In accordance with NMC guidelines on record keeping, Nurses record information as soon as possible after an event has occurred – to facilitate this nurse currently record information on daily residents list which can be transcribed to residents nursing records as soon as practical to do so. Visiting professionals are encouraged to record information in Residents multi-disciplinary treatment sheet. 12.11 – Three weekly menu cycles are used. Chef completed daily menu choice for resident the day before. Food charts are completed daily for all residents. 12.12 – Each Resident eating and drinking and nutritional risk is evaluated on a monthly basis or when there is a change in Residents eating pattern or a weight loss or gain. A discussion between Staff and Resident takes place including chef and family input is encouraged. Guideline from MUST are followed – food charts, appropriate referrals, Dietitians, S.A.L.T and GP.	Compliant

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<tr><td>Criterion 5.7
The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.
Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.7 – Day and Night Nurses record daily evaluation of care. Documented review of care plans is completed monthly by named nurses.
Residents where able and their representatives are involved in the review process.
Reviews by Care Managers are carried out on an agreed date and time by Care Manager, Resident Representative and Named Nurse or Manager or Deputy.
Outcome of reviews are documented and care plans amended if required.</td><td>Compliant</td></tr>
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<tr><td>Criterion 5.8
• Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.
Criterion 5.9
• The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>5.8 – Residents where appropriate are informed of planned review and invited to attend. They are given the opportunity to submit any information to the review meeting. Named nurse discuss care needs and review with the Resident/Representative. This is documented and signed by Patient/Representative in care record.
5.9 – Minutes of Care Review meeting are kept in patient notes, when received from Care Manager. The outcome of review meetings are documented in multi-disciplinary sheets. Any change of care is implemented and Nursing Care plan updated at this time. Relative’s communication sheet is used to record any information given to or received from Representative.</td><td>Compliant</td></tr>
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<tr><td>Criterion 12.1
• Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.
Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.
Criterion 12.3
• The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.
A choice is also offered to those on therapeutic or specific diets.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)</td><td></td></tr>
<tr><td>Provider's assessment of the nursing home's compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>12.1- Pre-admission and admission assessments provide information to assist staff to meet individual dietary and preferred needs. Guidance from other Health Care professionals is incorporated into Care Plans. Residents/Representatives are consulted about meal provision through monthly providers visit. Residents meetings and care reviews feedback is taken into account when reviewing menus in addition to guidance documents.
12.3 – All residents are offered a choice at each mealtime and alternative dishes are always available. The Chef liaises with Residents/Representatives the day before and records Residents choices. All meals can be modified to suit residents receiving therapeutic or specific diets</td><td>Compliant</td></tr>
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<tr><td>Criterion 8.6
• Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.
Criterion 12.5
• Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.
Criterion 12.10
• Staff are aware of any matters concerning patients’ eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:
o risks when patients are eating and drinking are managed
o required assistance is provided
o necessary aids and equipment are available for use.
Criterion 11.7
• Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20</td><td></td></tr>
<tr><td>Provider’s assessment of the nursing home’s compliance level against the criteria assessed within this section</td><td>Section compliance level</td></tr>
<tr><td>8.6 – Pre-admission assessments identify Residents with swallowing difficulties and the current treatment plan advised by Speech and Language Therapist, this care is continued after admission and continually re assessed. If a Resident develops swallowing difficulties a referral is made to S.A.L.T. All staff receive training in food and fluid preparation to meet assessed needs of Residents. Staff are kept up-to-date with any change in assessed needs and any recommendation made by S.A.L.T regarding consistency of meals and the feeding techniques, evidence of this can be found in care plans, and dietary needs recorded located on kitchen.
12.5 – Meals are provided at appropriate intervals throughout the day in keeping with nutritional guidelines. A choice</td><td>Compliant</td></tr>
</table>

of drinks and selection of snacks are offered mid-morning, afternoon and evenings. Fresh chilled water is available at all times from water coolers located on both floors. Residents may request drinks or snacks at any time fresh water/juice is provided for Residents who remain in their room. 12.10 – Staff are aware of Residents individual assessed needs, any change to assessed needs is documented in Care Plans, Daily progress notes, Communication sheet and dietary requirements sheets in kitchen. Staff are allocated during shift to assist Residents with meals. 11.7 – If a Resident requires wound care a registered nurse with expertise in wound management will carry out an assessment and draw up a wound care plan and apply appropriate dressing. Procedures are in place to consult Tissue Viability for Guidance/advice.	SubstantiallyCompliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	**COMPLIANCE LEVEL**
	Compliant

Quality Improvement Plan

Secondary Unannounced Care Inspection

Slemish House

11 January 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with (Mrs Dorothy McKeefrey**)** either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements **This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (NI) 2005**					
No.	**Regulation Reference**	**Requirements**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1.	25(a)	The registered person shall ensure that – (a) The Nursing and Midwifery Council (NMC) Code of Professional Conduct, Standards for Performance, Conduct and Ethics, and any other code of ethics or professional practice prepared by the NMC or body which is responsible for regulation of members of a healthcare professional is made available in the nursing home to nurse and healthcare professionals. Reference to this is made in that a review must be carried out with staff so that they are trained in ensuring that they have knowledge that entries to all care records must be legible and in accordance with the NMC standards on record keeping.	One	The Nursing and Midwifery Council (NMC) Code of Professional Conduct standards for Performance, Conduct and Ethics is available in the nursing home to nurses and Health care Professionals. The home will make available the 2009 guidelines on good record keeping. Staff will receive training in Record Keeping to ensure they have knowledge that entries to all Care Records are legible.	11 March 2015

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Dorothy McKeefry
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Ciaran Sheehan

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Lyn Buckley	26/01/15
Further information requested from provider			